

Gallia County Local Schools District
Confidential History Form

TODAY'S DATE _____ SCHOOL ENROLLING TODAY _____

STUDENT'S NAME: LAST _____ FIRST _____ MIDDLE _____

CURRENT GRADE: _____ DATE OF BIRTH ____/____/____ GENDER: M F

MOTHER'S NAME _____ PHONE: _____

FATHER'S NAME _____ PHONE: _____

CHILD LIVES WITH: MOTHER FATHER GRANDPARENT GUARDIAN OTHER _____

CHILD'S PRIMARY ADDRESS: _____

SIBLINGS AND AGES: _____

DOES YOUR CHILD HAVE: IEP YES NO 504 PLAN Y N SPECIAL EQUIPMENT Y N

DOES YOUR CHILD HAVE ALLERGIES (FOOD, MEDICATIONS, INSECTS, LATEX, ETC)? Y N

IF YES, PLEASE LIST ALLERGY AND TREATMENT _____

Please list any medications/treatments this student requires daily (even if not needed at school): _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO THIS STUDENT:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> No Health Conditions | <input type="checkbox"/> Vision Impairments | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> MusculoSkeletal Issues |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> amblyopia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> wears glasses/contacts | <input type="checkbox"/> Menstrual Issues | <input type="checkbox"/> Mental Health Concerns |
| <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> color vision deficits | | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiac Issues | <input type="checkbox"/> Kidney Issues | <input type="checkbox"/> Hearing Issues |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vascular Issues | <input type="checkbox"/> Liver Issues |
| | | | <input type="checkbox"/> Hearing Aides R L |

If you checked any of the above boxes, please describe the condition and current treatments:

If this student has had accidents or surgery, please list the dates and nature of each:

Please list any concerns not already listed that the school nurse/teacher need to address:

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I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that for the safety of my student, or to provide for their educational achievement, the school nurse may need to share information about my child with the appropriate school staff and/or associated agencies. Under the regulations of FERPA (Family Education Rights and Privacy Act of 1974), this information shall be shared in confidential manner only as necessary. If I do not want information shared, I must request this in writing and file this request with the school nurse.

In order for a child to receive over the counter medication (such as Tyfenol, Motrin), the parent/guardian will be contacted for permission to administer. Prescription medications, including inhalers and EpiPens, require completion of GCLS Authorization to Administer form by your physician and specific procedure for administering medication at school. Please ask for appropriate forms if needed.

This written validation will be in effect until otherwise noted or changed.

Signature of Parent/Guardian: _____ Date: _____